Group Health Benefits at a Glance 2010

Plan Feature	Group Health Gold	Group Health Silver	Group Health Bronze
Provider choice	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There's no coverage for out-of-network care unless indicated and approved/referred.		
Annual deductible	None		
Copay, unless otherwise indicated	You pay $20	You pay $35	You pay $50
After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 100% Out-of-network: Limited emergency/out-of-area care		
Annual out-of-pocket maximum	Network: $1,000/ person or $2,000/ family Out-of-network: Limited emergency/out-of-area care	Network: $2,000/ person or $4,000/ family Out-of-network: Limited emergency/out-of-area care	Network: $3,000/ person or $6,000/ family Out-of-network: Limited emergency/out-of-area care
After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	Network only: 100%		
Lifetime maximum	No limit		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)	Self-referrals to a network provider: $20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: $35 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: $50 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.
Ambulance services	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Chemical dependency treatment (requires preauthorization)	*For inpatient care:* 100% after $200 copay/admission *For outpatient care:* 100% after $20 copay/visit	*For inpatient care:* 100% after $400 copay/admission *For outpatient care:* 100% after $35 copay/visit	*For inpatient care:* 100% after $600 copay/admission *For outpatient care:* 100% after $50 copay/visit
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Diabetes care training	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	50% when preauthorized	50% when preauthorized
Emergency room care	Network: 100% after $100 copay/visit ($100 copay is waived, but $200 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived but $200 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered.**	Network: 100% after $100 copay/visit ($100 copay is waived, but $400 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived, but $400 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered.**	Network: 100% after $100 copay/visit ($100 copay is waived, but $600 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived, but $600 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered.**
Family planning	100% after $20 copay/visit **Infertility treatment is not covered.**	100% after $35 copay/visit **Infertility treatment is not covered.**	100% after $50 copay/visit **Infertility treatment is not covered.**
Growth hormones	Covered under prescription drugs with applicable copay when medically necessary		
Hearing aids	100%, up to $300/ear in 36 months		
Home health care	100%		
Hospice care	100% when preauthorized Certain limits apply; call plan for details.		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Hospital care	100% after $200 copay/admission	100% after $400 copay/admission	100% after $600 copay/admission
Inpatient care alternatives	100% when preauthorized		
Lab, X-ray and other diagnostic testing	100%		
Maternity care	*For delivery and related hospital care:* 100% after $200 copay/admission *For prenatal and postpartum care:* 100% after $20 copay/visit	*For delivery and related hospital care:* 100% after $400 copay/admission *For prenatal and postpartum care:* 100% after $35 copay/visit	*For delivery and related hospital care:* 100% after $800 copay/admission *For prenatal and postpartum care:* 100% after $50 copay/visit
Mental health care (requires preauthorization)	*For inpatient care:* 100% after $200 copay per admission *For outpatient care:* 100% after $20 copay/individual, family, couple or group session	*For inpatient care:* 100% after $400 copay per admission *For outpatient care:* 100% after $35 copay/individual, family, couple or group session	*For inpatient care:* 100% after $600 copay per admission *For outpatient care:* 100% after $50 copay/individual, family, couple or group session
Neurodevelopmental therapy for covered dependents age 6 and under	*For inpatient care:* 100% after $200 copay/admission, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/year (combined with rehabilitative services)	*For inpatient care:* 100% after $400 copay/admission, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $35 copay/visit, up to 60 visits/year (combined with rehabilitative services)	*For inpatient care:* 100% after $600 copay/admission, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $50 copay/visit, up to 60 visits/year (combined with rehabilitative services)
Out-of-area coverage—for example, while traveling or for your covered children away at school	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.		
Phenylketonuria (PKU) formula	100%		
Physician and other medical/surgical services	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/office visit	*For inpatient care:* 100% *For outpatient care:* 100% after $35 copay/office visit	*For inpatient care:* 100% *For outpatient care:* 100% after $50 copay/office visit

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after $10 copay Preferred brand: 100% after $20 copay Non-preferred brand: 100% after $30 copay Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.		
Prescription drug—Up to a 90-day supply through mail-order network only	Generic: 100% after $20 copay Preferred brand: 100% after $40 copay Non-preferred brand: 100% after $60 copay		
Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)
Radiation therapy, chemotherapy and respiratory therapy	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.	100% depending on services provided; copays may apply (including $200 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including $400 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including $600 copay/admission if hospital care is required)
Rehabilitative services—Inpatient and outpatient	*For inpatient care:* 100% after $200 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	*For inpatient care:* 100% after $400 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $35 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	*For inpatient care:* 100% after $600 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $50 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Smoking cessation	100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Free & Clear® Quit for Life™ Program, when prescribed by Group Health PCP No annual or lifetime limit		
Temporomandibular joint (TMJ) disorders	*For inpatient care:* 100% after $200 copay/admission *For outpatient care:* 100% after $20 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum	*For inpatient care:* 100% after $400 copay/admission *For outpatient care:* 100% after $35 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum	*For inpatient care:* 100% after $600 copay/admission *For outpatient care:* 100% after $50 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum
Transplants (certain services only)	100% after applicable copays Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered.		
Urgent care (ear infections, high fevers, minor burns)	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Vision exams	100% after $20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after $35 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after $50 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)